Lifestyle Care Management Ltd

Derwent Lodge Care Centre

Inspection report

Fern Grove
Off Hounslow Road
Feltham
Middlesex
TW14 9AY

Tel: 02088442975
Website: www.lifestylecare.co.uk

Date of inspection visit:
27 January 2016
28 January 2016

Date of publication:
15 March 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was carried out on 27 and 28 January 2016 and the first day was unannounced. This was the first inspection under the current registration with the Care Quality Commission.

Derwent Lodge Care Centre provides nursing care for up to 62 people. There are three floors and the units offer nursing care for older people including those with dementia care needs and people with physical disability needs. At the time of inspection there were 55 people using the service.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager has been in post since October 2015 and is applying for registration with CQC.

Care records reflected people's individual needs, interests and wishes, however the information was not always current and records were disorganised and sometimes difficult to read.

People were happy with the service and confirmed they felt safe living there.

Staff treated people with dignity and respect, listened to them and provided care and support in a caring and gentle way.

Risk assessments were in place to reflect the risk to individuals and the care and support they required to minimise these. Premises and equipment were being serviced and maintained to keep them in good working order.

There were suitable arrangements in place to ensure people were protected against the risks associated with the inappropriate treatment of medicines.

Staff understood safeguarding and whistleblowing procedures and were clear about the process to follow to report any suspicions of abuse. A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed at the service. Staff received regular training and updates understood people's individual choices and needs and how to meet them.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. However, information regarding DoLS authorisations was not identified in people's care records, which

could place people at risk of not having their best interests decisions met.

People's nutritional needs were identified and were being met. Input from the GP and other healthcare professionals was available to address any health concerns.

Staff understood people's needs and provided people with person-centred care. People's religious and social needs were being identified and met.

The manager was working to improve the service and provided meetings for people and relatives to express their views, with action being taken to address issues raised. Staff had mixed views regarding the management style and the manager was receptive to feedback we provided on this.

Systems were in place for monitoring the service and action was taken to address any issues identified.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The provider had arrangements in place to safeguard people against the risk of abuse.

Risk assessments were in place for identified areas of risk to minimise them. Maintenance and servicing of the premises and equipment took place to maintain a safe environment.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs.

The provider made suitable arrangements to ensure people were protected against the risks associated with the inappropriate treatment of medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Staff understood people's rights to make choices about their care but care records did not include relevant information relating to the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which could place people at risk not having their best interest decisions met.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being met.

People's healthcare needs were being monitored and they were referred to the GP and other healthcare professionals when necessary.

Is the service caring?

Good

The service was caring. People made choices about their care and staff treated people with dignity and respect.

Staff understood the individual care and support people needed and provided this in a gentle and caring way.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Care records did not always contain up to date care and treatment information and were disordered and difficult to navigate, so information could be missed.

People and relatives felt able to raise any concerns they might have and systems were in place to record and investigate these.

Is the service well-led?

Good

The service was well-led. The manager was appropriately qualified and experienced in care home management.

Meetings took place for people and relatives to encourage them to express their views about the service. Action was taken to address any areas they identified for improvement.

Systems were in place to monitor the quality of the service and areas for improvements were identified and addressed.

Derwent Lodge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 28 January 2016 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of three inspectors including a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience with older people including those with dementia care needs and of care services for older people.

During the inspection we viewed a variety of records including eight care records, the medicine supplies and medicines administration record charts for 12 people, four staff files, risk assessments, audit and monitoring reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the mealtime experience for people and interaction between people using the service and staff on all floors.

We spoke with fourteen people using the service, nine relatives, the manager, the deputy manager, five registered nurses, nine care staff, the activities coordinator, the chef, the maintenance person and the administrator. We also spoke with two healthcare professionals, those being a GP and a clinical nurse specialist in palliative care.

Good

Is the service safe?

Our findings

People confirmed they felt safe living at the service. We asked people about the response if they used their call bell. Comments included, "As a rule they come quickly" and "The carers are very good. They come running if I ring my bell."

Policies and procedures for safeguarding and whistleblowing were in place and were being followed. Staff told us they had received training in safeguarding and were able to provide definitions of different types of abuse. Staff said they knew how to report any safeguarding concerns and they would inform the unit nurse or other senior staff in the first instance. Staff also understood whistleblowing procedures and knew the outside agencies they could contact to report concerns including the local authority and the Care Quality Commission. The provider held monies on behalf of people using the service and we looked at a sample of records and saw all income and expenditure was clearly recorded and invoices were available for all expenditure. This meant monies held were being safely managed for people.

The service had a uniform, however we noted not all staff were wearing this. Also, some staff did not have name badges. This meant it was not always possible to identify staff members or their designation. Some relatives were concerned that this was confusing and potentially frightening for people if they saw an unfamiliar face. We spoke with the manager who was aware some staff needed uniforms and/or name badges and explained these had been ordered and she was expecting delivery of these shortly, so this would be addressed.

Risks were assessed so action could be taken to keep people safe. We saw risk assessments in the care files for individuals. Risk assessments had been undertaken and documented and these included for falls risk, risk of developing pressure sores and risk of malnutrition. Risk scores were updated monthly and where a risk had been identified the care plan highlighted ways to minimise or manage the risk. Risk assessments for equipment and safe working practices were in place and had been updated in the last year. The manager said these would be reviewed in line with the new provider to keep the information current. The fire risk assessments had been completed in December 2014 and issues identified had been recorded and addressed. Plans were in place to carry out the annual fire risk assessment under the current provider. Maintenance and servicing records were up to date and we saw systems and equipment including gas appliances, hoists, fire safety and equipment and lifts were being serviced at required intervals. One lift was out of order at the time of inspection and this had been reported for repair and identified so people were aware.

There was a system for recording accidents and incidents and staff were able to describe this. All accidents and incidents were recorded by the nursing staff on a standard form showing the name of the individual, date, time and place of the incident, details of any injury sustained and any follow up such as admission to hospital and action taken as a result of the incident. Accidents and incident records were viewed by the manager and any actions required were signed off when completed. There was a monthly analysis sheet for accidents and incidents and the manager said she reviewed these and if she identified any trends she would look into these and if necessary take action to minimise recurrence. The manager said the analysis sheets

were also checked when the audits of the service were carried out in order to look for trends.

Employment checks were carried out to ensure only suitable staff were being employed at the service. Completed application forms included education and employment histories and explanations for any gaps in employment were recorded. A medical questionnaire had been completed and pre-employment checks had been carried out including a Disclosure and Barring Service (DBS) check, references from previous employers, proof of identity and evidence of people's right to work in the UK. Some files did not have a recent photograph, however files did have copies of identification documents that included a photograph. The administrator addressed this at the time of inspection and said she would ensure photographs were taken promptly for new employees in future.

Staff commented that there were usually enough staff on duty but said that when care staff were absent unexpectedly they were sometimes short staffed. In one unit several people required assistance with eating and staff said that it was sometimes difficult to monitor people effectively at meal times. Some people and relatives reported that there were not always enough staff to assist people and perform other duties. One person said, "Some people need two staff to use the hoist which means that other people aren't properly supervised in the lounge." We observed at the time of our inspection that there were enough staff on duty to attend to people's needs, and staff were on hand to assist people to dress, move around the home or get to their rooms as required. We spoke with the manager who explained they had been actively recruiting for new staff. She explained this was alongside ensuring current staff on full time contracts were being flexible and available to cover duties so weekends as well as weekdays could be fully staffed.

We asked people if they received their medicines safely. On person said, "I think they're very careful about medications. I haven't had a mistake made. If you have to have it at a certain time you get it at that time." The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the supplying pharmacy and the provider, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. These showed good governance processes in response to two safeguarding alerts that had occurred recently at the service. The manager stated that no medicines incidents/ near misses had been reported since the last safeguarding incident. However, they demonstrated the correct process verbally of what to do should an incident/near miss arise in the future, including who to contact. This was in line with the provider's policy.

People received their medicines as prescribed, including controlled drugs. We looked at 12 Medicines Administration Records (MAR) and found no discrepancies in the recording of medicines administered. Furthermore, all remaining stock quantities that were recorded on the MAR reconciled exactly to those contained in the respective blister packs. This was confirmed with two people who reported that they received their medicines in a timely and correct manner. We observed a registered nurse administer medicines in a safe, caring and effective manner to people during the afternoon medicine round. Also, we observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them.

Medicines were stored and locked away appropriately in the treatment rooms. Medicines requiring disposal were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Room and fridge temperatures were audited on a daily basis and in-range, and controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff.

People's behaviours were not controlled by excessive or inappropriate use of medicines. For example, we

saw 12 PRN forms for pain-relief/agitation medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its' intended benefit. This was also demonstrated verbally by a registered nurse we spoke with. We did find one instance where a PRN protocol had not been completed for a person's inhaler, which the team leader resolved immediately once notified.

We found that people received their medicines, in line with the Mental Capacity Act 2005. We observed six people's MARs whose medicines were administered covertly. We found that all of them had an individualised protocol and the appropriate authorisations from the GP, pharmacist and a relative were sought and documented on a 'Covert Medication Form'. This included the practicalities of administration, information on the crushing of tablets and how often it was to be reviewed. Although we did not initially see evidence of a best interests meeting for each person, this was confirmed later with the manager who showed us a DOLs assessment, which included information on medicines by the assessor. This assured us that a best interests meeting had taken place for each person who was administered medicines covertly.

The manager confirmed she was happy with the provider's arrangement with the supplying community pharmacy, and felt that the provider received appropriate support with regards to the training of nursing staff of high risk medicines such as warfarin. The manager said she would be meeting with the GP to review how they could improve processes for receiving blood results and prescriptions in a timely way. The manager said the GP carried out a medicines review for each person at least every six months. This was evidenced by checking the record of a medicines review that had been carried out within the last six months, the manager confirmed that at least one GP from the same surgery visited every week to see people using the service.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that while staff listened to people and offered them choices along with encouraging them to make decisions where they were able to do so, some care staff were not clear about the principles of the MCA or requirements relating to DoLS and said that they had not yet received training in this area. We viewed training information and 24 staff were recorded as having done training in MCA and DoLS between August and October 2015 and the manager said more training was being planned under the new provider. Capacity assessment forms were seen in care records relating to different aspects of care, such as resuscitation decisions, consent to photographs, use of bedrails and covert medication administration although there was no consistency with regard to the location of the forms or their completion. Some had been fully completed, signed and dated while others were incomplete or had been signed without date, name or designation. One form had been incorrectly filed in another person's care file.

There was no evidence in people's care records of assessments by medical professionals with regard to mental capacity or of best interest meetings, related documentation or decisions in relation to deprivation of liberty safeguards, even though authorisations had been applied for. There were 18 people on DoLS authorisations at the time of the inspection and we saw meetings had taken place in respect of these. The documentation was kept in the manager's office. However, this information had not been transferred to people's care records so the information was not easily available to those who were providing people's care. This meant that information on relevant assessments and decisions that impacted on people's care was not always accessible or effectively documented. The importance of ensuring information regarding people's mental capacity and DoLS status was available to staff was discussed with the manager who said this would be addressed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care files contained completed 'do not attempt resuscitation' (DNAR) forms at the front of the file and those seen were the official forms and had been completed correctly and authorised by the GP. There was evidence of discussion with the person if they had capacity, or, if not, their representative. The care files also contained an advanced decision section which gave an indication of wishes with regard to resuscitation and these reflected the DNAR decision.

Overall people felt they were receiving the care and input they needed. Comments from people included,

"My doctor is arranging for me to have physiotherapy [but] there's no facilities for doing exercises." "They are looking after me very well." "So far I am very happy with here. The manager came to the hospital to do an assessment." A relative said, "The staff do a pretty good job."

Staff received training to provide them with the skills and knowledge to care for people effectively. Care staff confirmed they had regular training so that their skills and knowledge were kept up to date. They considered that the amount of training provided was adequate and explained that training now took place using online learning modules. Some staff were concerned that online learning gave no opportunity to ask questions or clarify any uncertainty about the training received, and commented that there should be reinforcement of training within the work environment. The deputy manager said some training topics also had practical elements, for example, moving and handling, so staff received theory and practical training. She also explained that in order to pass the online training modules staff completed a test and had to gain 100% and if they did not they would have to repeat the training until they did. The deputy manager was available to staff to discuss any concern or the need for clarification regarding training. Staff gave examples of recent training they had undertaken including health and safety, safeguarding and food hygiene.

Newer care staff outlined the induction process for new employees, including mandatory training, corporate induction and a period of shadowing and supervision, so they had training to carry out their roles. Staff said they had regular one to one supervision sessions every two to three months and annual appraisals at which training and performance could be discussed. These were undertaken by unit heads for care staff and by the manager or deputy manager for nursing staff. Group supervisions had also taken place to discuss specific topics such as maintaining people's privacy and abuse awareness. Records of supervisions and appraisals were maintained to evidence these had taken place.

People using the service were generally satisfied with the food, and comments included, "We get a choice of two things. It's alright. Not Cordon Bleu, just normal food." The eating and drinking care plan indicated preferences, likes/dislikes, support people required with eating and any allergies. Any specific dietary requirements were recorded such as a diabetic diet, the need for soft or pureed food and any religious or cultural needs. Nutritional status had been assessed and everyone receiving care had a care plan for eating and drinking. Weight was monitored on a monthly basis and the malnutrition universal screening tool assessment (MUST) was used and scores were up to date.

People's dietary needs and preferences were well documented in the kitchen. The kitchen staff maintained a file for each floor with a list of people with details of dietary needs showing any specific requirements such as fortified food, vegetarian choices, pureed food, diabetic diet and any particular likes/dislikes and any special requests or preferences. All food was prepared from fresh and transferred in heated trolleys to the dining rooms on each floor at mealtimes. The current monthly menu plan was kept in the kitchen and was balanced and nutritious. The chef told us that people selected their meal choices for planning purposes but could change their minds on the day if they chose or ask for alternative meals if they wished. We saw this when someone did not like the two options available and staff promptly took action to get them an alternative, which they enjoyed.

We saw staff were available to assist people with their meals and food was provided at the correct consistency for people, for example, a pureed meal and thickened fluids for someone identified as being at risk of choking. As well as breakfast, lunch and supper there was a trolley serving morning and afternoon tea/coffee. Water and juice were available throughout the day and other drinks on request, so people's dietary and hydration needs were being met.

People received input from healthcare professionals to maintain their health. We met with two healthcare

professionals who confirmed people were referred to them appropriately for input and felt people were being well cared for at the service. One said of the staff, "They welcome me and want to progress and that is to be admired." They told us staff provided the care and treatment people needed to improve, for example, improvement in the condition of a pressure sore. Input from health care professionals was recorded in care records and included the date of the visit, their name and designation, the reason for the visit and the outcome. GP visits had been documented and there was evidence of visits from other healthcare professionals including optician, dentist and chiropodist, plus details of hospital appointments.

Good

Is the service caring?

Our findings

We asked people their opinions about the care they received. Comments included, "I love it here, it's like being at home. The staff are lovely and I get all the help I need.", "I'm very happy here – the staff are very good, I've got everything I need.", "[The carers] are all good. I get on all right with everybody; I give them a bit of cheek. It's no good being miserable.", "It's home from home really. They can't do enough for you.", "I've only been here a week, but it's alright, okay, you know?", "It's okay here, but it's not like being at home. I take everything as it comes. I'm easy going." and "Some of [the carers] are alright."

We also received positive feedback from relatives. Their comments included, "The staff are very good, some are wonderful.", "The staff are very kind, very obliging and we always feel welcome when we come in.", "[Staff] is a diamond. She's been a real friend to [relative].", "You cannot say enough about how lovely they are." and "They are good. Very, very good. To be honest they can't do enough for you. I think they could do with some more staff; not so much during the week, but at weekends it's very busy sometimes. [Person] seems quite happy whenever I come, she's washed thoroughly. You can't fault it. When I was looking for a home for [relative] I popped in here and they showed me around. Right away I felt this was a good place. If you'd seen [relative] a year ago, I didn't think she would make it. I would put my own name down for a room here."

Care staff were friendly, gentle and cheerful and showed patience with people, helping them to mobilise carefully and communicating clearly with them. Staff understood people's different needs, abilities, preferences and personalities and took time to acknowledge and accommodate their needs. We asked staff what was important to them when caring for people. One told us, "It is important to laugh with people and make them happy. To show patience and understanding. If you want to be respected you have to respect them." We saw people felt comfortable to 'be themselves', for example, a person talking and joking with care staff, demonstrating a good sense of humour and bantering with staff, which staff reacted well to. People's cultural and religious wishes and beliefs were identified in the care plans. The activities coordinator said representatives from the Church of England and the Roman Catholic Church visited the service regularly and each month there was a Christian church service. Bedrooms were personalised with people's possessions, pictures etc. Some rooms displayed a photograph and name of the person on the door and this helped people to recognise where their room was.

People's preferences and routines were well documented in care plans, including their preferred term of address and preferred waking and retiring times. Care staff said they sometimes read the care plans but mainly relied on information from other staff to learn about people's care needs. When asked, staff were able to outline individual needs and were familiar with different people's routines and preferences, demonstrating they understood these. We saw staff interacting well with people at mealtimes and there was a good atmosphere on the first and second floors at lunchtime. The mealtime experience on the ground floor was somewhat quiet and communication was kept to essential conversation rather than encouraging a sociable and interactive time for people. We saw this had already been identified by the provider as an issue and the manager said this was an area they were working on to improve the mealtime experience for people living on the ground floor.

We observed people's privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care. We saw someone looking concerned and staff recognised they needed assistance to the toilet, which was provided promptly. We saw that staff always knocked on bedroom doors before entering. People were supported to get up when they were ready to do so and people looked cared for and were well dressed. Some people were engaged in activities in the lounges and others were able to sit in other communal areas or remain in their rooms.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always reflect people's current care needs, which could leave them at risk of not having their needs met. There were person-centred care plans for each aspect of care, outlining the assessed need or condition, the objective of the care plan and the care and support the person required. They also contained daily notes and a monthly evaluation sheet for each care plan, which was completed and signed by nursing staff to record progress and any changes and these were up to date. For one person the daily records detailed challenging behaviour patterns and staff confirmed that this person could be verbally abusive and did not verbalise effectively. However, the care plan stated that the person could communicate their needs, there was no detailed information on how to support the person and no meaningful detail was recorded in the monthly reviews. We saw in other records that care needs were accurately documented and suitable monitoring was in place to track progress, for example, for one person who had a well maintained behaviour diary. We found information from healthcare professionals visits had not always been transferred to the relevant care record. For example, there was documentation of input from the tissue viability nurse specialist seen in wound care files but visits had not been recorded in the healthcare professionals log, similarly dietician visits had taken place but had not been recorded in all cases. This meant people were receiving healthcare input but the records did not always reflect this.

Although files contained a significant amount of information about people, they were inconsistent and disordered, with duplicated or missing information in several cases. Legibility was often very poor. In some cases care plans did not reflect, or contradicted, the assessment of needs done on or prior to admission even for those who had been admitted recently. In one case the medical care plan did not include the identified medical history which was relevant to the care of the person, or the main goals of care which had been specified in the pre-admission assessment. When we asked staff they were able to report clearly on the person's needs and progress but this had not been reflected in the care plan. Identified risks had not always been transferred into the care plans. For example, a person had been identified as being at very high risk of developing pressure sores but this had not been referenced in the care plan. The person's skin was intact, indicating they were receiving relevant care, so records needed to be updated to accurately reflect the care they required and were receiving. There was a limited amount of documentation of care reviews in the care records, with some having taken place several months or more previously.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care files contained a pre-admission assessment of needs as well as an admission assessment, which covered medical history, physical, psychological and social needs and levels of dependency. The assessments were comprehensive and covered all aspects of people's needs.
There was a communication diary on each floor which recorded issues of note such as reminders of visits or appointments and any areas of concern. These diaries were well maintained and were up to date.

The majority of people and relatives we asked could not recall seeing a care plan, however they said they had met with staff regularly to review care needs and had opportunities to discuss any changes, so that the

support provided was in line with current needs. One relative told us, "It's a pretty reasonable place. They're very friendly. I was involved in writing my [relative's] care plan." Records of communication with relatives were available in some files and these included the date and detail of the contact and any action agreed.

We saw a sample of care records that had been audited and these were thorough, identified the shortfalls on an action plan and the points had been signed off and dated when they had been addressed. The service was planning to introduce a new system of care files to replace those currently used. We viewed one and saw these would provide a more logical and accessible format of care records. The manager said with the introduction of this paperwork the plan was to ensure all care records were maintained accurately and time would be given for staff to complete these in a timely way.

People felt staff were responsive to their needs. Comments included, "Everything is here for you, it's good and they look after you. I've got no complaints.", "They said I could bring as much as I wanted to make my room look like home. The man here fitted up my TV for me and hung the pictures." A relative said, "When [relative] arrived here they put him on the first floor. It wasn't right for him up there and he didn't like it so they moved us to the ground floor as soon as this room was ready. They were redecorating it."

Relatives were also positive about the way the service responded to their family member's needs. Comments included, "Once a month they take them on outings: to Staines, Walton on Thames, shopping trips, ten pin bowling. [Relative] enjoys playing Bingo which the activity co-ordinator organises. I always find everyone friendly and helpful. [Relative] has been happy whilst she's been here, I didn't think she would be.", "They offered to facilitate [relative] going to her club, a day centre place she used to go to before she came here after she arrived, but she didn't want to. [My relative] likes to stay up all night sometimes, and they let her do that.", "I wondered why [relative] is not put in a chair during the day but now I realise it's because she gets quite agitated and is happier in bed. She's always been a loner. The entertainment and the parties they put on, you could go on and on" and "[Relative] doesn't join in any of the activities; it's his choice." The person concerned also agreed with this.

The activities coordinator had worked at the service for several years. She said she gained information about people's interests from them, from their relatives and from the care records. Each care file had a 'Life Story' booklet which had been completed by the person or a family member/friend to provide a personal profile with information on background, employment history, family, hobbies, significant relationships and other relevant information. Four had been well completed and provided a comprehensive history about the person. Several people had mentioned the activities coordinator to us by name and people liked her. She had been playing her guitar and singing during the first morning of inspection and people were seen enjoying this. She told us this was an activity she could take to people in their rooms, as well as giving them manicures and talking with them. The activities coordinator said she aimed to greet everyone each day and to spend at least ten minutes each week on a one to one basis with them. She knew those who enjoyed individual activities such as puzzle books and knitting and had also arranged some baking groups which people had also enjoyed. She told us about a person with late stage dementia who did not usually speak anymore, but she said when she sang to them "she comes out with some words and I feel pleased".

The activities coordinator had sourced a special audio production specifically for people with dementia care needs, which we heard playing during the inspection and people seemed to be enjoying it. Birthdays were identified and these were celebrated with a cake and a celebration. We observed some good interactions between carers and people and a catering staff member with the tea trolley was chatting with people as they went around. The activities coordinator said she was working with the staff so they realised activities were a part of each person's daily routine and she felt she was receiving support from the staff with this.

The service had a complaints procedure and this was displayed in the entrance area. The service user guide also contained a copy of the document. The service did not have any complaints recorded from people or relatives since the new provider had taken over. Feedback from people and relatives regarding complaints was mixed. Most were unable to recall seeing an official complaints procedure and two people were unsure who they would complain to if they had concerns. Two relatives said they had raised issues but did not feel this had made a difference. Another relative who had raised a care concern said this had been addressed effectively with significant improvements. A record of a meeting to discuss these concerns was seen in this person's care record. In one person's room we saw a sign on the wall giving instructions on which clothes could be laundered by the service and which were to be taken away for washing. I asked the relative present how amenable the service had been to this arrangement and they said they were quite happy with it. The manager said she would ensure people had copies of the complaints procedure and would continue to encourage people and relatives to express any concerns so they could be addressed.

Good

Is the service well-led?

Our findings

The manager had been in post since October 2015 and was in the process of applying for registration with CQC. She had a recognised qualification in management and was experienced in managing care homes for older people. The manager said the provider was being supportive of her efforts to improve the service.

Staff we spoke with commented that the new manager had made improvements to the service and was very well organised. Some said that the service had improved due to the strong leadership shown by the manager and felt she had brought about improvements for people and their relatives. Comments from staff included, "The new manager is wonderful, she's very organised I wish she had been here earlier." "I've worked here fifteen years. I think the new manager is trying. We will see" and "She's strict but that's good as she gets things done." However, some staff found her management style very direct and that she was not always receptive when they wished to discuss a matter. One member of staff said, "I'm scared to speak to her" and some staff reported they felt demoralised. We fed this back to the manager who took on board our comments and said she would look at her approach when communicating with staff. People and relatives were aware there had been a recent change of ownership and management of the service. Comments from relatives included, "It's changed hands twice since we came here" and "I think I have a good relationship with the manager in the time we've been here."

Staff reported that there were monthly staff meetings in the home as well as more regular meetings on each unit to discuss the running of the service and any concerns or issues about individual people. We saw the minutes from these meetings and where issues were identified action had been taken by the manager to address them, for example, promoting good communication and teamwork between day and night staff so all staff knew they had a clear role to play in maintaining good standards in the service. We saw that issues we had identified such as legibility and completion of records had been brought up at staff meetings, showing the manager had already identified such issues with the staff. Meetings had also taken place for people using the service and for relatives. The minutes showed that where issues had been raised action had been taken to address them, for example, laundry not being returned to rooms had been addressed. We saw in the minutes of meetings with relatives there had been an improvement noted, for example, where people had raised concerns about the laundry service action had been taken to address this.

The provider had carried out a full audit of the service in October 2015 and the manager had drawn up an action plan to address shortfalls identified, which we saw was being progressed. Several audits had been carried out in December 2015 including for care plans, pressure relieving equipment and bedding, so these were being monitored. Monthly monitoring of individual needs also took place, for example, monitoring of skin tears, pressure sores and invasive devices such as catheters so action could be taken to identify any issues and address them. The maintenance person carried out monitoring checks for premises and equipment including fire equipment, water outlets and temperature checks to ensure these were safe and in working order. A mealtime audit had identified issues on the ground floor and the manager said this was being worked on with staff to improve communication at mealtimes.

The manager told us she had access to a variety of useful websites and publications to keep up to date with

current guidance and good practices, including the provider's intranet and weekly information bulletins and other nursing publications. Policies and procedures covering all aspects of the service and people's care were in place and had been updated in December 2015 to keep the information current. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c).